Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws.

If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

EMPLOYER GROUP

Texas PPO

Humana ChoiceCare Network

Humana Member Handbook

Insured by Humana Insurance Company

Humana®

TXHHTCPEN 0123

Table of contents

This communication provides a general description of certain insurance benefits provided under one or more of our health benefit plans. Our health benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For complete plan details, refer to the Certificate of Insurance or contact our Customer Care department. In the event of any disagreement between this communication and the Certificate of Insurance, the Certificate of Insurance will control.

Prospective members can view a sample Certificate of Insurance on **Humana.com**. Plan specific information is also provided on the Summary of Benefits and Coverage (SBC). Prospective members can contact the benefits coordinator of their employer for a copy of the SBC. Members can access their plan specific SBC and Certificate of Insurance through MyHumana on **Humana.com.**

Insuring company statement

This Humana plan is a Preferred Provider Organization (PPO) plan insured by Humana Insurance Company.

Important phone numbers

As a Humana member, you can call our Customer Care department toll-free at the number on the back of your Humana member ID card when you have questions about your plan. We make every effort to answer your calls quickly. Our hours are 8 a.m. – 6 p.m., Monday – Friday. If you have comments on our service or ideas on how we can improve, please call
800-448- 6262 (TTY: 711) or write to:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Humana ID card

You'll be issued a Humana member ID card to show that you're a member of the plan. Be sure to carry it with you at all times. You'll need to present the card anytime you receive medical care. If your Humana member ID card is lost or damaged, you can get a new one on MyHumana or by calling our Customer Care department at 800-448-6262 (TTY: 711).

Special needs

Humana strives to make it easy for all members to use the benefits provided by their plan. If you need help due to a disability or chronic medical problem that has affected your vision, hearing, speech or mobility, please call our Customer Care department at the number on the back of your Humana member ID card. If you use TTY, call 711.

MyHumana

MyHumana is your secure, personal online member account on **Humana.com**. It's one of the best ways to get information about your plan. With MyHumana, you can get answers to questions about your health plan when you want them. You can look up records 24 hours a day. Here are some of the things you can do on MyHumana:

- Find in-network providers.
- Look at your health plan benefits.
- See if a claim has been paid.
- Compare costs of medical services.
- Explore health and wellness information.

It's easy to register. Have your Humana member ID card ready when you go to **Humana.com**. Select "Register now," then follow the brief directions.

How to use your Humana plan

With this Humana PPO Plan, you can choose to obtain covered services from any provider either in-network or out-of-network. An in-network provider has signed an agreement with us to provide covered services to you. The amount you pay to an in-network provider for covered services will generally be lower than if you receive covered services from an out-of-network provider. An out-of-network provider has not signed an agreement with us and you will generally pay more when an out-of-network provider provides covered services to you, except as otherwise indicated in the Certificate of Insurance.

Get the most from your healthcare coverage by knowing your plan and following these simple guidelines:

- Always carry your Humana member ID card and show it when you receive medical care.
- You do not need to have one healthcare practitioner to coordinate your care, however, it's always a good idea to have one physician you trust and see for your annual physical exam and who understands your overall health status. Typically, this would be a physician who is a family practitioner, pediatrician or who specializes in internal medicine. With a Humana PPO Plan, you can select any physician either in or out of the PPO network. Your out-of-pocket expenses will be lower by receiving care from in-network health care providers.
- If you need specialized care, you can use any in-network or out-of-network specialist or healthcare provider of your choice. Your out-of-pocket expenses will be lower by using an in-network specialist.
- In an emergency, always go to the nearest emergency facility. Refer to your Certificate of Insurance for benefit information.

- Let us know immediately about changes that affect your coverage. You must tell us if you move, marry, divorce, or add a child. By calling our Customer Care department for an enrollment change form. If you use TTY, call 711.

Please read your Summary of Benefits and Coverage (SBC)and the Certificate of Insurance for details to help you get the most out of your plan.

Provider relationships

Our relationship with qualified providers

A qualified provider means a healthcare provider that is licensed by the appropriate state agency to provide preventive care or diagnose or treat sickness or injury, provides such services within the scope of their license, and whose primary purpose is to provide healthcare services. Qualified providers are not our agents, employees, or partners. All providers are independent contractors. Qualified providers make their own clinical judgments or give their own treatment advice without coverage decisions made by us.

The policy will not change what is decided between you and qualified providers regarding your medical condition or treatment options. Qualified providers act on your behalf when they order services. All decisions related to your care are the responsibility of you and the healthcare providers you choose to care for you, regardless of any coverage determination(s) we have made or will make. We are not responsible for anything said or written by a qualified provider about covered services and/or what is not covered. If you have any questions, call our Customer Care department at the telephone number listed on your ID card. If you use TTY, call 711.

Our financial arrangements with in-network providers

We have agreements with in-network providers that may have different payment arrangements.

- Many in-network providers are paid on a discounted fee-for-services basis, meaning they have agreed to be paid a set amount for each covered service given to a covered person.

- Some in-network providers may have capitation agreements, meaning they are paid a set dollar amount each month to care for each covered person no matter how many services a covered person may receive from the in-network provider, such as a primary care physician or specialty care physician.

- Hospitals may be paid on a Diagnosis Related Group (DRG) basis or flat-fee-per day basis for services provided to covered persons while hospital confined. Outpatient services are usually paid on a flat-fee-per service or procedure or a discount from normal charges.

Highlights of your plan

Your Humana PPO Plan provides coverage for a wide range of services, including:

- Preventive care
- Physician services
- Hospital services
- Durable medical equipment
- Home health services
- Hospice services
- Physical, occupational, and speech therapy
- Skilled nursing facility services
- Urgent care
- Behavioral health services
- X-ray and laboratory
- Maternity services
- Transplants
- Prescription drugs
- Children's vision care (not included in all plans)
- Children's dental care (not included in all plans)
- Emergency care services
- Ambulance services

A brief description of the above-listed services covered by the plan is provided below. This is not a complete list or description of all services covered by the plan. For complete details about covered services, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on **Humana.com**.

Preventive care

Your plan includes coverage for preventive care, such as:

- A health risk assessment.
- Routine physical exams.
- Well-child care.
- Necessary immunizations - it's important for you and your family to get all your immunizations because they help the body fight disease. Children may need certain immunizations before they can start school. Your child's physician will tell you when immunizations are required.
- An annual well-woman exam.
- Prostate cancer detection exam.

Physician services

- **Choosing or changing your physician**

With the Humana PPO plan, you have the freedom to use any in-network or out-of-network provider. Your out-of-pocket expenses will be lower by receiving care from an in-network healthcare provider. While you don't need to have one healthcare physician to coordinate your care, it's always a good idea to have one physician you trust and see for your healthcare needs. This person can get to know you and your medical history and give you health advice. Typically, this is a physician who is a family practitioner, pediatrician or who specializes in internal medicine. This provider can:

- Provide most of your medical care.
- Keep your medical records.
- Guide you when you need special care.

There is a "Find a doctor" tool on **Humana.com** and on your personal MyHumana page that you can use to choose a physician in your plan's network. You may also request a printed copy of a physician list or get help finding an in-network physician by calling our Customer Care department at 800-448-6262 (TTY: 711). The physician list for your network includes service areas, by county or ZIP code, and listings of facilities and physicians along with their addresses and contact information. The physician list is subject to change. Due to the possibility of in-network providers changing status, be sure to check the physician list online or call our Customer Care department prior to obtaining services.

- **Visiting your physician**

Whenever you need to see your physician, simply call the physician's office and make an appointment. If you're going to be late for an appointment, call the office and tell them. If you can't keep an appointment, call the office as soon as possible to reschedule. Please try to give notice at least 24 hours in advance or you may be billed by a provider based on their cancellation rules. You should make an appointment to meet your physician to review your general health. This gives your physician the chance to get to know you and your medical history. After your first visit, your physician may recommend a checkup or a routine appointment. Your physician may determine you need specialist services. With a Humana PPO plan, you have the freedom to receive care from any in-network specialist or out-of-network specialist. Your out-of-pocket expense will be lower by using an in-network provider.

- **Specialized care**

Your plan covers a wide range of specialized medical services. When you need specialized care, you'll want to use the "Find a doctor" tool found on **Humana.com** and also on your personal MyHumana page to find a specialist in your plan's network. You may also request a printed copy of a physician list by calling our Customer Care department at 800-448-6262 (TTY: 711). The physician list is subject to change. Due to the possibility of in-network providers changing status, be sure to check the physician list online or call our Customer Care department prior to obtaining services. Remember you have the freedom to receive care from any in-network or out-of-network specialist, but your out-of-pocket expenses will be lower by using an in-network healthcare provider.

- **Virtual visit services**

This plan covers virtual visits for the diagnosis and treatment of a sickness or bodily injury. Virtual visits must be for services that would otherwise be a covered service if provided during a face-to-face consultation between you and the provider.

- **Access to services after hours**

If you have medical questions or concerns, you can call your physician's office 24 hours a day, seven days a week.

- **Outpatient care**

Covered healthcare services are subject to the limitations and exclusions in your plan. Office visits, diagnostic lab tests and X-rays, and outpatient surgery are included in the plan coverage.

- **Network changes**

To get the most from your health plan coverage, make sure the physician you choose currently participates in your plan's network and will accept new patients. Visit **Humana.com** and select "Find a doctor." Complete the required information on the "Find a doctor" page to perform a search for in-network providers. If you prefer, call our Customer Care department at the number on the back of your Humana member ID card, if you use TTY, call 711.

Hospital services

If you need hospital care, you have the freedom to go to any hospital of your choice. However, your out-of-pocket expenses will be lower by going to an in-network healthcare facility. Additionally, your plan may require, as a condition of coverage, that certain medical conditions be treated at specific facilities.

Your Humana plan provides:

- **In-network inpatient care**

- As many days as medically necessary, in a semi-private room (private room when authorized by your physician due to medical necessity).
- Preadmission testing.
- Supplies and services.
- Services from a healthcare provider, who directs your care while you're in an inpatient facility.

- **In-network outpatient care**
- Outpatient surgery.
- Outpatient diagnostic services.

Durable medical equipment

Durable medical equipment means equipment that meets all of the criteria as listed in your Certificate of Insurance. Coverage may be provided for rental or purchase of durable medical equipment. If the cost of renting the equipment is more than its purchase price, only the cost of the purchase will be covered. However, certain items aren't covered, including tub chairs, elastic supports and environmental control items. You may obtain the preauthorization list online at **Humana.com/pal** or call our Customer Care department at 800-448-6262 (TTY: 711) to confirm coverage and preauthorization requirements.

Home health services

Humana's Utilization Management department or our contracted utilization review agent, along with your physician, arranges:

- Home nursing care.
- Medical social work.
- Nutrition services.
- Physical, occupational, respiratory, and speech therapies.

Your healthcare providers and Humana will help you to determine what home healthcare needs are medically necessary and covered under your plan.

Nursing care must be by or under the supervision of a registered nurse or licensed practical nurse. Medically necessary appliances and equipment and laboratory services also may be covered. Review your Certificate of Insurance for applicable limitations of this benefit.

Hospice services

Inpatient and outpatient hospice services are a covered benefit. Refer to your Certificate of Insurance for more information

Physical, occupational, and speech therapies

Your plan covers rehabilitative services including physical, occupational, and speech. therapies. Preauthorization may be required. Therapy is covered only if that treatment, in the judgment of your physician, will significantly improve your condition. Review your Certificate of Insurance for applicable limitations of this benefit.

Skilled nursing facility services

For details and limitations on care in a skilled nursing facility, including physician visits during your stay, refer to your Certificate of Insurance. Custodial care isn't covered.

Urgent care

If you have a sickness or bodily injury requiring prompt medical attention, but it isn't an emergency or a life-threatening situation, contact your physician or go to an urgent care facility near you.

Behavioral health services

Your plan covers services for inpatient and outpatient mental healthcare, serious mental illness and chemical dependency. Refer to your Certificate of Insurance for more information.

X-ray and laboratory

Your plan covers:

- Diagnostic X-ray exams and imaging.
- Lab tests and analysis for diagnosis or treatment.
- Radiation therapy.

Some X-ray and lab services may require preauthorization. Call our Customer Care number at 800-448-6262 (TTY: 711) to verify.

Maternity services

Hospital room and board (semi-private accommodation), services and supplies while confined in the hospital and physician care are covered under the plan. This includes the cost and administration of anesthetics. Coverage also includes prenatal and postnatal care and medically necessary testing in a physician's office.

HumanaBeginnings® is dedicated to helping Humana members make healthy decisions throughout pregnancy. The program combines personal contact with a registered nurse and informative mailings. Members can:

- Find out more about their pregnancy.
- Follow their baby's development.
- Receive guidance about healthy habits to practice along the way.

If you'd like more information about HumanaBeginnings®, or if you're a Humana member who's expecting a baby, call us toll-free at 888-847-9960 (TTY: 711).

Transplants

You or your physician must call Humana's Transplant Management Department at 866- 421-5663 (TTY: 711) as soon as you, or a covered dependent, make the decision to proceed with a covered transplant. The Transplant Management Department will provide assistance and coordinate all of your covered transplant services with an approved Transplant facility. This will maximize the benefits of your health plan. Review your Certificate of Insurance for applicable limitations of this benefit.

Prescription drugs

To have a prescription filled, simply go to any in-network pharmacy and show your Humana member ID card. You are required to pay a copayment or a portion of the drug cost for each prescription based on the assigned level of the drug as specified on the drug list. You can obtain a copy of the drug list at **Humana.com/druglist** or call our Customer Care department at the number on the back of your Humana member ID card, if you use TTY, call 711. Information on the drug list may change at the renewal of the group plan. We will provide written notice no later than 60 days prior to the effective date of the change.

Descriptions of the various prescription drug benefits are provided below. To determine which prescription drug benefit is applicable to your plan, please review the plan

materials provided to you, including your Certificate of Insurance. As a member, you can also visit **Humana.com** and sign in to MyHumana to view your cost-share for prescription drug benefits.

- **Rx3 Prescription Drug Benefit**

Covered prescription drugs are assigned to one of three different levels with corresponding copayment or coinsurance amounts. Specialty drugs are also indicated. The levels are organized as follows:

- **Level One**: Includes generic drugs.
- **Level Two**: Includes preferred brand-name drugs.
- **Level Three**: Includes higher-cost brand-name drugs.
- **Specialty Drugs**: High-cost/high-technology drugs that often require special dispensing conditions.

- **Rx4 Prescription Drug Benefit**

Covered prescription drugs are assigned to one of four different levels with corresponding copayment or coinsurance amounts. Specialty drugs are also indicated. The levels are organized as follows:

- **Level One**: Includes low-cost generic drugs and brand-name drugs.
- **Level Two**: Includes higher-cost generic drugs and brand-name drugs.
- **Level Three**: Includes high-cost, mostly brand-name drugs. These drugs may have generic drug or brand-name drug alternatives in Levels One or Two.
- **Level Four**: Includes highest-cost drugs.
- **Specialty Drugs**: High-cost/high-technology drugs that often require special dispensing conditions.

- **Rx5 Prescription Drug Benefit**

Covered prescription drugs are assigned to one of five different levels with corresponding copayment or coinsurance amounts. The levels are organized as follows:

- **Level One**: Includes preferred, lowest-cost generic drugs.
- **Level Two**: Includes low-cost generic drugs.
- **Level Three**: Includes higher-cost generic and preferred brand-name drugs.
- **Level Four**: Includes non-preferred brand-name and high-cost generic drugs.
- **Level Five**: Includes highest-cost/high-technology drugs and specialty drugs.

DISPENSE AS WRITTEN: If you request a brand-name drug when an equivalent generic drug is available, your cost may be greater. Refer to the Certificate of Insurance for specific benefit information.

Children's vision care

Some Humana PPO Plans include children's vision care. Please see the specific plan documents, including your Certificate of Insurance to see if Children's vision care is included in your plan and for more information on this benefit.

Children's dental care

Some Humana PPO Plans include children's dental care. Please see the specific plan documents, including your Certificate of Insurance, to see if Children's dental care is included in your plan and for more information on this benefit.

Emergency care services

- **What is emergency care?**

Emergency care means services provided in a hospital emergency facility, free-standing emergency medical care facility, or a comparable emergency facility to evaluate and stabilize an emergency medical condition. Emergency care does not mean services for the convenience of the covered person or the provider of treatment or services.

Emergency medical condition means a recent onset of a bodily injury or sickness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

- **Seeking emergency care**

When seeking emergency care, you should:

- Go to the nearest hospital emergency facility, free-standing emergency medical care facility, or comparable emergency facility.
- You, or someone on your behalf, must contact us within 48 hours of your admission to a hospital for emergency care.

- **Out-of-area coverage**

The service area is the area where the plan provides coverage. The Humana PPO plan includes a broad national network of healthcare providers so that you and your eligible dependents are covered regardless of geographic location.

For details about emergency care coverage, refer to your Certificate of Insurance. After receiving emergency care, it's a good idea to notify your physician and Humana within 48 hours, or as soon as possible. Call Humana at 800-448-6262 (TTY: 711).

Ambulance services

Ambulance service must be transportation to, from, or between medical facilities for an emergency medical condition. For details about Ambulance services, refer to your Certificate of Insurance.

The information above is not a complete list or description of all of your benefits. Not all services or supplies your physician may order or suggest are covered benefits under your plan. This is the case even when your physician refers you to other in-network providers for services. For complete details about covered services, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on **Humana.com**.

Facility-based physician disclosure

Although covered services may be or have been provided to you at a healthcare treatment facility that is an in-network provider, other professional services may be or have been provided at or through the health care treatment facility by physicians and other healthcare practitioners who are out-of-network providers. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan unless balance billing for those services is prohibited. Covered health services provided by a facility-based physician or other healthcare practitioner may include emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic laboratory and radiology services.

Your financial responsibilities

Covered services

You are responsible to pay any deductible, coinsurance, and copayment to a provider for covered services you receive. In-network providers have agreed to accept discounted or negotiated fees for covered services and will not bill you for charges in excess of the negotiated fees. Plan specific deductibles, coinsurance and copayments are provided in the Summary of Benefits and Coverage (SBC) for prospective members and on the Schedule of Benefits in the members' Certificate of Insurance. Prospective members can obtain the SBC from the benefits coordinator of the employer or insurance agent. Members can view their plan specific Certificate of Insurance by accessing MyHumana on **Humana.com**.

Non-covered services

If you obtain non-covered services, whether from an in-network provider or an out-of-network provider, you're responsible for making the full payment to the healthcare provider Refer to your Certificate of Insurance for complete information. Prospective members can view a sample Certificate of Insurance on **Humana.com**.

Limitations and exclusions

Unless specifically stated otherwise in the Certificate of Insurance, no benefits will be provided for or on account of the following items:

- Treatments, services, supplies, or surgeries that are not medically necessary, except for preventive services.
- A sickness or bodily injury that is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
- Care and treatment given in a hospital owned or run by any government entity, unless you are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to covered persons who are armed services retirees and their dependents are not excluded.
- Any service you receive while you are confined in a hospital or institution owned or operated by the United States government or any of its agencies for sickness or bodily injury connected to military service.
- Services, or any portion of a service, for which no charge is made.
- Services, or any portion of a service, you would not be required to pay for, or would not have been charged for, in the absence of this coverage.
- Any portion of the amount we determine you owe for a service that the provider waives, rebates or discounts, including your copayment, deductible or coinsurance.
- Sickness or bodily injury for which you are paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a healthcare practitioner.
- Any drug, biological product, device, medical treatment, or procedure which is experimental or investigational or for research purposes except for clinical trials.
- Legend drugs, which are not deemed medically necessary by Humana.
- Prescription drugs not included on the drug list.
- Drugs not approved by the FDA.
- Any drug prescribed for intended use other than for indications approved by the FDA or off-label indications recognized through peer-reviewed medical literature.
- Any drug prescribed for a sickness or bodily injury not covered under the plan.
- Any drug, medicine, or medication that is either labeled "Caution-limited by federal law to investigational use" or experimental, investigational or for research purposes, even though a charge is made to you.
- Any prescription fill or refill for drugs, medicines, or medications that are lost stolen, spilled, spoiled, or damaged.

This is not a complete list of the plan's Limitations and Exclusions. For a complete listing, refer to your Certificate of Insurance. Prospective members can view a sample Certificate of Insurance on **Humana.com**.

Preauthorization requirements

Humana requires preauthorization for some services and supplies and procedures your physician or healthcare provider may recommend for you. Visit our website at **Humana.com/pal** or by calling our Customer Care department at the number on the back of your ID card to receive a list of services requiring preauthorization and information about the preauthorization process. The list of services and supplies that require preauthorization is subject to change and notification of changes are provided as required by state law. Benefits are not paid at all for services or supplies that are not covered expenses. Preauthorization is not required for emergency care or any other services not permitted to be preauthorized by law.

Preauthorization means you or your physician or healthcare provider will contact Humana before you receive services. Humana does this to determine whether the service or procedure qualifies for payment under your benefit plan. Some network providers may qualify for an exemption from the preauthorization requirements as required by state law. You and your healthcare provider decide whether you should have the services or procedures.

Your in-network provider is responsible for preauthorizing services and any resulting payment reduction when a required preauthorization is not obtained. You are responsible for making sure services to be provided by an out-of-network provider are preauthorized and you will be responsible for any payment reduction when a required preauthorization is not obtained.

Renewal of an existing preauthorization may be requested up to sixty days prior to the expiration of the existing preauthorization.

Utilization management

The Humana call center or a utilization review agent contracted with Humana manages calls from healthcare providers to fulfill the requirements of notification and preauthorization of members' inpatient admissions. Certain procedure or durable medical equipment (DME) requests may require review to determine coverage.

Humana contracts with various utilization review companies (utilization review agents) to assist with preauthorization reviews, concurrent reviews or retrospective reviews. Concurrent review is the process that determines coverage during the length of stay in the hospital/acute rehab/skilled nursing facility. Retrospective review is the process to determine coverage of inpatient services when prospective preadmission notification and other reviews aren't obtained. When this occurs, the claim information for an inpatient stay that is not preauthorized is directed to the Utilization Management Department or to one of Humana's contracted utilization review agents. If we deny

services based on an adverse determination of medical necessity, you can appeal the decision. Refer to the "Complaint and Appeals Procedures" section within this handbook.

If you have questions or concerns or wish to contact the utilization review agent conducting your review you may contact Humana at 800-448-6262 (TTY: 711) to obtain information on how to contact either the Utilization Review Department at Humana or the agent assigned by Humana to conduct your specific utilization review or preauthorization. You can find an updated preauthorization list on **Humana.com/pal.**

Continuity of care

You may be eligible to elect continuity of care if you are a continuing care patient as of the date the following events occur:

- Your qualified provider terminates as a network provider.
- The terms of a network provider's participation in the network changes in a manner that terminates a benefit for a service you are receiving as a continuing care patient, or
- The policy terminates.

If you elect continuity of care, we will apply the network provider benefit level to covered services related to your treatment as a continuing care patient. You will be responsible for the network provider copayment, deductible and/or coinsurance until the earlier of:

- 90 days from the date we notify you the qualified provider is no longer a network provider.
- 90 days from the date we notify you the terms of a network provider's participation in the network changes in a manner that terminates a benefit for a service you are receiving as a continuing care patient.
- 90 days from the date we notify you this policy terminates.
- In the case of a pregnancy, through the delivery of a child, including immediate post-partum care and follow-up visit within the first six weeks of delivery.
- In the case of a terminal illness, nine months from the date we notify you the qualified provider is no longer a network provider or nine months from the date we notify you the terms of a network provider's participation in the network changes in a manner that terminates a benefit for a service you are receiving as a continuing care patient, or
- The date you are no longer a continuing care patient.

For the purposes of this "Continuity of care" provision, continuing care patient means at the time continuity of care becomes available, you are undergoing treatment from the network provider for:

- A disability.
- An acute sickness or bodily injury.
- A life-threatening or complex sickness or bodily injury.
- Inpatient care.
- A scheduled non-elective surgery and any related post-surgical care

- A pregnancy, or;
- A terminal illness.

Continuity of care is not available if:

- The qualified provider's participation in our network is terminated due to failure to meet applicable quality standards, medical competence, professional behavior, or fraud.
- You transition to another qualified provider.
- The services you receive are not related to your treatment as a continuing care patient.
- This "Continuity of care" provision is exhausted, or
- Your coverage terminates, however the policy remains in effect.

All terms and provisions of the policy are applicable to this "Continuity of care" provision.

Complaint and Appeals Procedures

If you have a complaint

We want you to be happy with your Humana plan. If you aren't satisfied with the healthcare or services you receive, please call our Customer Care phone number at 800-448-6262 (TTY: 711). If you're not satisfied with the results of your call, you can file a formal complaint by writing to:

Humana Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

We will not retaliate in any way if you or any person acting on your behalf files an appeal or complaint against us.

Please refer to the information below when filing a formal complaint.

Complaint procedures

"Complaint" means any dissatisfaction you express orally or in writing to us about any aspect of our operation. This includes, but isn't limited to:

- Dissatisfaction with plan administration
- How we provide a service
- Disenrollment decisions
- Procedures related to the review or appeal of an adverse determination
- Procedures related to the denial, reduction or termination of a service for reasons not related to medical necessity.

A complaint isn't a misunderstanding or a problem of misinformation that's resolved by supplying appropriate information to your satisfaction. It also doesn't include adverse determinations.

If you notify us of a complaint, we will send you a letter acknowledging the date we received the complaint within five business days of the receipt of the complaint. The letter will include Humana's complaint procedures and time frames for resolution.

If the complaint was received by phone, we will send you a one-page complaint form clearly stating the form must be returned to us for prompt resolution of the complaint. After receipt of the written complaint or one-page complaint form from you, we will investigate and send you a letter with our resolution within 30 days of our receipt of the complaint.

If the complaint is not resolved to your satisfaction, you have the right to appear in person or address a written appeal to a complaint appeal panel. Notice of our final decision will be provided within 30 calendar days from receipt of the request for a complaint appeal panel.

Internal appeal of adverse determination

"Adverse determination" means a determination by Humana or a utilization review agent that the healthcare services provided or proposed to be provided to a member are not medically necessary, appropriate, experimental, investigational, or are protected under the Federal No Surprises Act. Adverse determination does not include a denial of healthcare services due to the failure to request prospective or concurrent utilization review.

The member, anyone acting on the member's behalf or provider has the right to appeal an adverse determination. When we receive an appeal, we will, within five business days from the receipt of the appeal, send a letter to the appealing party acknowledging the date of our receipt of the appeal. This letter will include the appeal procedures and the time frames required for resolution. If an appeal of an adverse determination is received verbally, a one-page appeal form will be included with an acknowledgment letter to the appealing party.

After review of the appeal of the adverse determination, we'll issue a response letter to the member or a person acting on behalf of the member and the member's physician or healthcare provider.

This letter will explain the resolution of the appeal as soon as is practical. This will take place before the 30th calendar day from when we receive the appeal.

If the appeal is for emergency care, denial of a continued stay for hospitalized patients, or denial of prescriptions drugs or intravenous infusions, we'll base the time frame for resolution on the medical or dental immediacy of the condition, procedure or treatment. This won't exceed one working day from the date we receive all information necessary to complete the appeal. The resolution letter will contain the clinical basis for the appeal's denial, the specialty of the healthcare practitioner making the denial, and notice of the claimant's right to seek review of the denial by an Independent Review Organization.

Filing complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint and appeal process and who aren't satisfied with the resolution, can get help with a question or file a complaint with the state:

Call with a question: 800-252-3439
File a complaint: **www.tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**
Mail: Texas Department of Insurance
Consumer Protection Section
MC: CO-CP
P.O. Box 12030, Austin, TX 78711-2030

The Texas Department of Insurance will investigate a complaint against us to determine compliance. This will happen within 60 days of the Texas Department of Insurance's receipt of the complaint and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation if:

- Additional information is necessary
- We, the provider or the member doesn't provide all documentation necessary to complete the investigation.
- An on-site review is necessary; or
- Other circumstances beyond the control of the department occur

External appeal to an Independent Review Organization (IRO)

An Independent Review Organization (IRO) process is available to you. Refer to your Certificate of Insurance for the IRO process.

Member services

Open enrollment

Employers usually set aside time for changing from one healthcare plan to another or for making changes in coverage. At other times, changes in your enrollment can generally be made if:

- You lose your group health plan coverage; or
- Your family size changes due to marriage, divorce, or birth or adoption of a child.

Enrollment changes for these reasons must generally be made within 31 days of the event. Check with your employer for group-specific provisions.

Dependent coverage

Eligible dependents generally include your spouse and children up to a specified age. Check your Certificate of Insurance for more information.

Loss of coverage

With some Humana plans, you may lose your coverage if you move from the plan service area. Humana can remove you from the Humana PPO plan if you:

- Fail to pay plan premiums; or
- Commit fraud or make an intentional misrepresentation of a material fact.

Effective date of coverage

Your effective date of coverage, and when you are first eligible to receive plan benefits, is determined by your employer. Ask your personnel office or benefits administrator for information about your effective date.

Plan status change

If you have individual coverage with your employer and want to change to the family plan, you must notify your employer of the new change within the number of days specified in your Certificate of Insurance. Please ask your employer about changes in coverage.

Keep us up to date

Please notify our Customer Care department whenever there's a change in your name, address, or telephone number.

Plan provisions

Continuation of benefits

If your group coverage ends, you may be allowed to continue coverage through your employer. Ask your company's benefits administrator or refer to your Certificate of Insurance.

Coordination of benefits

If you or your family members are covered by more than one healthcare plan, you can't collect full benefits from both plans. In this case, Humana will work with the other plan to decide which plan will have primary responsibility for paying for your medical care. To help us do this, we may ask you for information about other coverage you may have.

Remember that each healthcare plan may require you to follow certain rules or use specific physicians and hospitals. It may be impossible to comply with both plans at the same time. Be sure to read and understand the rules for any healthcare plan that covers you or your family.

Filing a claim

In-network providers will submit claims to us on your behalf. If you receive covered services from an out-of-network provider, you may be asked to pay the out-of-network

provider directly and submit a notice of claim to Humana. In that case, you should obtain a receipt, an itemized statement and any medical records associated with your care. The forms necessary for filing these claims are available on **Humana.com**.

Submit copies of these to the Humana Claims department at:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Within 15 business days of receiving satisfactory proof-of-loss, we will provide you with a written notice of our decision to accept or reject a claim or provide reasons why additional time is needed to make a decision. A decision will be made within 45 days of the date of our letter. If the claim is accepted, it will be paid in whole or in part within five days of the written approval notice you receive.

If your claim is denied and you aren't reimbursed, you may ask to have the claim reviewed. If you have any questions about the review procedure, call our Customer Care department.

Your rights and responsibilities

As a Humana member, you have certain rights and responsibilities.

You have the right to:

- Be provided with information about your Humana PPO plan, its services and benefits, its providers and your member rights and responsibilities.
- Choose either in-network or out-of-network healthcare providers. Your out-of-pocket expenses will be lower by using the services of in-network providers.
- Privacy and confidentiality regarding your medical care and records. Records pertaining to your healthcare will not be released without your, or your authorized representative's, written permission, except as permitted or required by law.
- Discuss your medical record with your physician and receive, upon request, a summary copy of that record.
- Be informed of your diagnosis, treatment choices including non-treatment and prognosis in terms you can reasonably expect to understand and to participate in decision-making about your healthcare and treatment plan.
- Have a candid discussion with your physician about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services regardless of race, national origin, religion, physical abilities or source of payment.
- File a formal complaint, as outlined in the plan's appeal procedure, and to expect a response to that complaint within a reasonable period of time.

- Be treated with courtesy and respect with appreciation for your dignity and protection of your right to privacy.
- Participate in wellness programs.
- Receive assistance from Humana's Customer Care specialists to address your concerns and questions.

It's your responsibility to:

- Give Humana and your healthcare provider complete and accurate information as needed to arrange care for you.
- Read and be aware of all material distributed by Humana about the plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information you may need or desire to give informed consent for a procedure or treatment.
- Follow the treatment plan agreed on with your healthcare provider and to weigh the potential consequences of any refusal to observe those instructions or recommendations.
- Be considerate and cooperative in dealing with the plan providers and to respect the rights of other plan members.
- Schedule appointments, arrive on time for scheduled visits and notify your healthcare provider if you must cancel or be late for a scheduled appointment.
- Express opinions, concerns or complaints in a constructive manner.
- Tell us in writing if you move or change your address or phone number, even if these changes are only temporary.
- Pay all copayments, deductibles and/or premiums by the date when they are due.
- Be honest and open with your physician and report unexpected changes in your condition in a timely fashion.
- Follow healthcare facility rules and regulations affecting patient care and conduct.
- Carry your Humana member ID card with you at all times and use it while enrolled in the Humana plan.

Provider Network Information

A current list of in-network providers, including behavioral health and substance abuse providers can be found online at **Humana.com** with the "Find a doctor" tool. You also may request a printed copy of the physician list by calling our Customer Care department at 800-448-6262 (TTY: 711). We offer many healthcare plans. A provider that is an in-network provider for one plan may not be an in-network provider for your plan. It is important for you to ensure the physician list is specific for the provider network listed on your ID card. The physician list includes names, locations and contact information for all

physicians and providers in your network and whether new patients are being accepted. Please note, the in-network physician list is subject to change. Due to the possibility of in-network providers changing status, be sure to check the online physician list of in-network providers or call our Customer Care department prior to obtaining services.

Attention Female Enrollees

Right to designate an obstetrician or gynecologist

This notice is being provided to advise the member of rights under Texas Insurance Code, Chapter 1451 Subchapter F:

You have direct access to receive gynecological and obstetrical care from an in-network or out-of-network obstetrician or gynecologist (OB/GYN), but your out-of-pocket expenses will be lower by using an in-network provider.

Notice of rights

- You have the right to an adequate network of preferred providers (also known as "in-network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- You have the right, in most cases, to obtain estimates in advance:

  - From out-of-network providers of what they will charge for their services; and
  - From your insurer of what it will pay for the services.

- You may obtain a current directory of in-network providers at the following website **Humana.com** or by calling our toll free Customer care department at the telephone number shown on your ID card, if you use TTY, call 711 for assistance in finding available preferred providers.

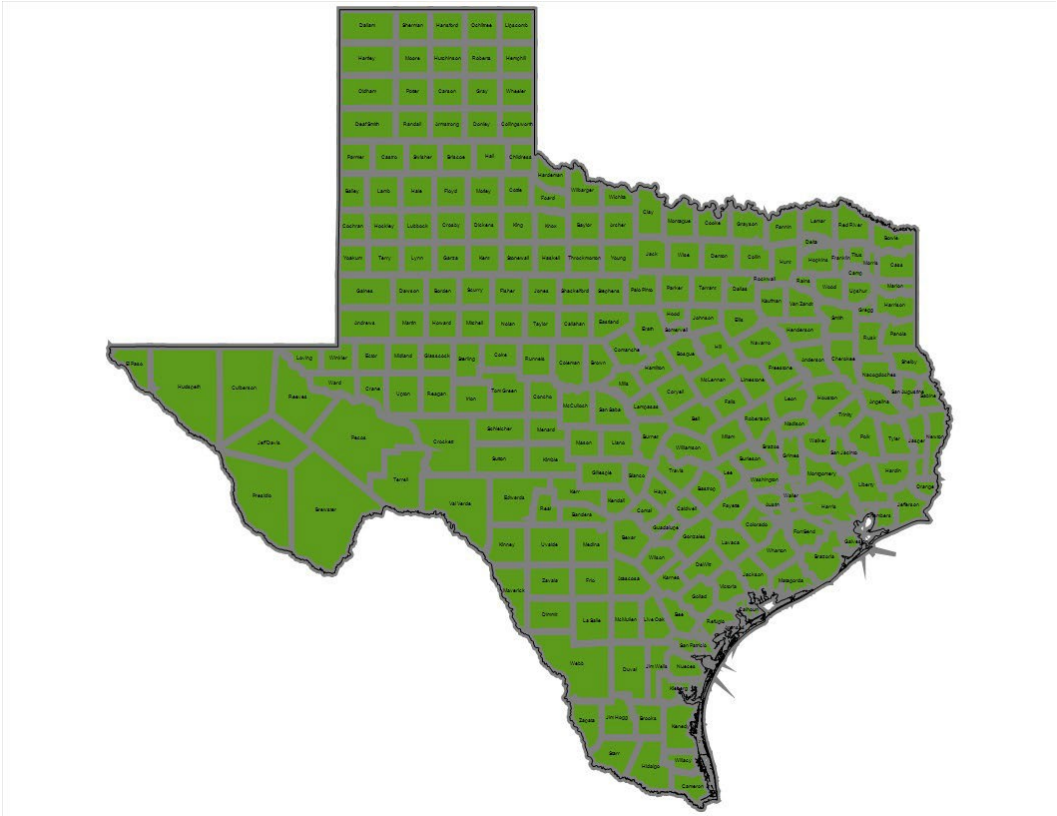
- If you are treated by a provider or facility that is not an in-network provider, you may be billed for fees in addition to any deductible, coinsurance and copayments, unless balance billing is prohibited.

- If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of- pocket maximum.

Service area (Humana ChoiceCare PPO Network)

Service area means the geographic area designated by us and approved by the Department of Insurance of the state in which the certificate is issued. This Humana PPO plan, gives you the freedom to choose any provider, either in-network or out-of-network, for covered services. The Humana ChoiceCare PPO Network service area in Texas includes these counties in the following Regions:

- Region 1—Panhandle, including Amarillo and Lubbock.
- Region 2—Northwest Texas, including Wichita Falls and Abilene.
- Region 3—Metroplex, including Fort Worth and Dallas.
- Region 4—Northeast Texas, including Tyler.
- Region 5—Southeast Texas, including Beaumont.
- Region 6—Gulf Coast, including Houston and Huntsville.
- Region 7—Central Texas, including Austin and Waco.
- Region 8—South Central Texas, including San Antonio.
- Region 9—West Texas, including Midland, Odessa, and San Angelo.
- Region 10—Far West Texas, including El Paso.
  Region 11—Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo.



Member demographic information

Provider network demographic information (ChoiceCare PPO Network)

Number of insureds by geographic region

- Region 1: 133
- Region 2: 8
- Region 3: 1,729
- Region 4: 38
- Region 5: 21
- Region 6: 255
- Region 7: 356
- Region 8: 3,255
- Region 9: 77
- Region 10: 0
- Region 11: 2,950

Number of in-network providers for the following areas of practice by geographic region

Region 1:

- Internal medicine practitioners: 60
- Family/General practitioners: 246
- Pediatricians: 70 Refer to access plan
- Obstetricians and Gynecologists: 59 Refer to access plan
- Anesthesiologists: 210 Refer to access plan
- Psychiatrists: 21 Refer to access plan
- General Surgeons: 72 Refer to access plan

Region 2:

- Internal medicine practitioners: 54
- Family/General practitioners: 177
- Pediatricians: 31 Refer to access plan
- Obstetricians and Gynecologists: 54 Refer to access plan
- Anesthesiologists: 207 Refer to access plan
- Psychiatrists: 25 Refer to access plan
- General Surgeons: 31 Refer to access plan

Region 3:

- Internal medicine practitioners: 810
- Family/General practitioners: 1,542
- Pediatricians: 829
- Obstetricians and Gynecologists: 983
- Anesthesiologists: 3,415 Refer to access plan
- Psychiatrists: 529
- General Surgeons: 953

Region 4:

- Internal medicine practitioners: 113
- Family/General practitioners: 474
- Pediatricians: 90 Refer to access plan
- Obstetricians and Gynecologists: 123
- Anesthesiologists: 470 Refer to access plan
- Psychiatrists: 63
- General Surgeons: 92

Region 5:

- Internal medicine practitioners: 58 Refer to access plan
- Family/General practitioners: 127 Refer to access plan
- Pediatricians: 41 Refer to access plan
- Obstetricians and Gynecologists: 57
- Anesthesiologists: 58 Refer to access plan
- Psychiatrists: 134
- General Surgeons: 11

Region 6:

- Internal medicine practitioners: 817
- Family/General practitioners: 1,595
- Pediatricians: 1,322
- Obstetricians and Gynecologists: 1,267
- Anesthesiologists: 2,719 Refer to access plan
- Psychiatrists: 614
- General Surgeons: 581

Region 7:

- Internal medicine practitioners: 313
- Family/General practitioners: 1,119
- Pediatricians: 450 Refer to access plan
- Obstetricians and Gynecologists: 511
- Anesthesiologists: 1,485 Refer to access plan
- Psychiatrists: 492
- General Surgeons: 240

Region 8:

- Internal medicine practitioners: 279
- Family/General practitioners: 709
- Pediatricians: 405 Refer to access plan
- Obstetricians and Gynecologists: 458 Refer to access plan
- Anesthesiologists: 1,998 Refer to access plan
- Psychiatrists: 351 Refer to access plan
- General Surgeons: 335 Refer to access plan

Region 9:

- Internal medicine practitioners: 53 Refer to access plan
- Family/General practitioners: 118 Refer to access plan
- Pediatricians: 67 Refer to access plan
- Obstetricians and Gynecologists: 66 Refer to access plan
- Anesthesiologists: 104 Refer to access plan
- Psychiatrists: 55 Refer to access plan
- General Surgeons: 24 Refer to access plan

Region 10:

- Internal medicine practitioners: 86 Refer to access plan
- Family/General practitioners: 218 Refer to access plan
- Pediatricians: 90 Refer to access plan
- Obstetricians and Gynecologists: 119 Refer to access plan
- Anesthesiologists: 95 Refer to access plan
- Psychiatrists: 133 Refer to access plan
- General Surgeons: 50 Refer to access plan

Region 11:

- Internal medicine practitioners: 178 Refer to access plan
- Family/General practitioners: 531 Refer to access plan
- Pediatricians: 295 Refer to access plan
- Obstetricians and Gynecologists: 171
- Anesthesiologists: 491 Refer to access plan
- Psychiatrists: 70
- General Surgeons: 98

Number of in-network hospitals by geographic region

- Region 1: 32
- Region 2: 23
- Region 3: 90
- Region 4: 17 Refer to access plan
- Region 5: 12
- Region 6: 60
- Region 7: 50
- Region 8: 60 Refer to access plan
- Region 9: 17 Refer to access plan
- Region 10: 10 Refer to access plan
- Region 11: 28 Refer to access plan

Waivers or local market access plans

If the "Provider network demographic information" states "Refer to access plan" for a network provider or hospital in a region, the access plan can be viewed on our website **Humana.com** under the "Find a doctor" page selecting "View printed directories." For assistance in obtaining a copy of an access plan, call our Customer Care department phone number on the back of your Humana ID card, if you use TTY, call 711. for assistance in obtaining a copy of an access plan.